

		FOR OHF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041608</u> Facility Name: <u>ASTA CARE CENTER OF ELGIN</u> Address: <u>134 N. MCCLEAN BOULEVARD</u> <u>ELGIN</u> <u>60123</u> <div style="display: flex; justify-content: space-between; width: 100%;"> Number City Zip Code </div> County: <u>KANE</u> Telephone Number: <u>(847) 742-8822</u> Fax # <u>(847) 742-9013</u> IDPA ID Number: <u>36-4069629</u> Date of Initial License for Current Owners: <u>03/29/96</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608 Report Period Beginning: 01/01/2000 Ending: 12/31/2000**III. STATISTICAL DATA**A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>52</u>	Skilled (SNF)	<u>52</u>	<u>19,032</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>50</u>	Intermediate (ICF)	<u>50</u>	<u>18,300</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>102</u>	TOTALS	<u>102</u>	<u>37,332</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,624</u>	<u>1,624</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>22,880</u>	<u>4,640</u>		<u>27,520</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,880</u>	<u>4,640</u>	<u>1,624</u>	<u>29,144</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 78.07%)

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started _____

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date _____ NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 24 and days of care provided 849Medicare Intermediary ADMINASTAR**IV. ACCOUNTING BASIS**MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **ASTA CARE CENTER OF ELGIN** # **0041608** Report Period Beginning: **01/01/2000** Ending: **12/31/2000**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	163,260	17,358	5,655	186,273		186,273	0	186,273		1
2	Food Purchase		99,182		99,182		99,182	(1,099)	98,083		2
3	Housekeeping	163,799	17,618	0	181,417		181,417	0	181,417		3
4	Laundry	40,093	8,042	745	48,880		48,880	0	48,880		4
5	Heat and Other Utilities			83,757	83,757		83,757	0	83,757		5
6	Maintenance	28,248	20,426	34,517	83,191		83,191	(4,046)	79,145		6
7	Other (specify):*			16,052	16,052		16,052	0	16,052		7
8	TOTAL General Services	395,400	162,626	140,726	698,752		698,752	(5,145)	693,607		8
	B. Health Care and Programs										
9	Medical Director			6,500	6,500		6,500	0	6,500		9
10	Nursing and Medical Records	852,234	48,212	8,205	908,651		908,651	0	908,651		10
10a	Therapy	42,021	1,648	3,700	47,369		47,369	0	47,369		10a
11	Activities	47,082	6,897	2,809	56,788		56,788	0	56,788		11
12	Social Services	25,866		0	25,866		25,866	0	25,866		12
13	Nurse Aide Training			0				0			13
14	Program Transportation			0				0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	967,203	56,757	21,214	1,045,174		1,045,174		1,045,174		16
	C. General Administration										
17	Administrative	67,798		161,590	229,388		229,388	(128,092)	101,296		17
18	Directors Fees							0			18
19	Professional Services			40,449	40,449		40,449	3,765	44,214		19
20	Dues, Fees, Subscriptions & Promotions			23,674	23,674		23,674	(11,579)	12,095		20
21	Clerical & General Office Expense	133,412	15,888	26,288	175,588		175,588	63,825	239,413		21
22	Employee Benefits & Payroll Taxes			215,828	215,828		215,828	0	215,828		22
23	Inservice Training & Education			3,115	3,115		3,115	0	3,115		23
24	Travel and Seminar			0				420	420		24
25	Other Admin. Staff Transportation			2,090	2,090		2,090	5,546	7,636		25
26	Insurance-Prop.Liab.Malpractice			19,777	19,777		19,777	1,059	20,836		26
27	Other (specify):*			29,081	29,081		29,081	(19,952)	9,129		27
28	TOTAL General Administration	201,210	15,888	521,892	738,990		738,990	(85,008)	653,982		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,563,813	235,271	683,832	2,482,916		2,482,916	(90,153)	2,392,763		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			23,977	23,977		23,977	(7,702)	16,275		30
31	Amortization of Pre-Op. & Org.			1,164	1,164		1,164	0	1,164		31
32	Interest			32,626	32,626		32,626	(490)	32,136		32
33	Real Estate Taxes			62,619	62,619		62,619	0	62,619		33
34	Rent-Facility & Grounds			428,007	428,007		428,007	0	428,007		34
35	Rent-Equipment & Vehicles			7,185	7,185		7,185	3,212	10,397		35
36	Other (specify):*							0			36
37	TOTAL Ownership			555,578	555,578		555,578	(4,980)	550,598		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers			105,506	105,506		105,506	0	105,506		39
40	Barber and Beauty Shops							0			40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			55,998	55,998		55,998	0	55,998		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers			161,504	161,504		161,504		161,504		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,563,813	235,271	1,400,914	3,199,998	0	3,199,998	(95,133)	3,104,865		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **ASTA CARE CENTER OF ELGIN**

0041608

Report Period Beginning: **01/01/2000**

Ending: **2/31/2000**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(7,702)	30		9
10	Interest and Other Investment Income	(490)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,099)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties		21		18
19	Entertainment	0	20		19
20	Contributions	(3,300)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	(29,081)	27		24
25	Fund Raising, Advertising and Promotional	(8,312)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(4,046)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,030)		\$	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(41,103)	SCHED	34
35	Other- Attach Schedule	0	ATTACHED	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (41,103)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (95,133)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb ASTA CARE CENTER OF ELGIN

0041608 Report Period Beginning:

01/01/2000

Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2	Food Purchase	(1,099)	0	0	0	0	0	0	0	0	0	0	(1,099) 2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	(1,099)	0	0	0	0	0	0	0	0	0	0	(1,099) 8
B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Program	0	0	0	0	0	0	0	0	0	0	0	0 16
C. General Administration													
17	Administrative	0	(128,092)	0	0	0	0	0	0	0	0	0	(128,092) 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	0	3,765	0	0	0	0	0	0	0	0	0	3,765 19
20	Fees, Subscriptions & Promotions	(11,612)	33	0	0	0	0	0	0	0	0	0	(11,579) 20
21	Clerical & General Office Expenses	0	63,825	0	0	0	0	0	0	0	0	0	63,825 21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	0	420	0	0	0	0	0	0	0	0	0	420 24
25	Other Admin. Staff Transportation	0	5,546	0	0	0	0	0	0	0	0	0	5,546 25
26	Insurance-Prop.Liab.Malpractice	0	1,059	0	0	0	0	0	0	0	0	0	1,059 26
27	Other (specify):*	(29,081)	9,129	0	0	0	0	0	0	0	0	0	(19,952) 27
28	TOTAL General Administration	(40,693)	(44,315)	0	0	0	0	0	0	0	0	0	(85,008) 28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(41,792)	(44,315)	0	0	0	0	0	0	0	0	0	(86,107) 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number: ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginning:

01/01/2000 Ending:

12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(7,702)	0	0	0	0	0	0	0	0	0	0	(7,702)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(490)	0	0	0	0	0	0	0	0	0	0	(490)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	3,212	0	0	0	0	0	0	0	0	0	3,212	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(8,192)	3,212	0	0	0	0	0	0	0	0	0	(4,980)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(49,984)	(41,103)	0	0	0	0	0	0	0	0	0	(91,087)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number: **ANTARES CENTER OF ELGIN** STATE OF ILLINOIS Report Period Beginning: **01/01/2009** Ending: **12/31/2009** Page: **4**

VENUE: **VENUE** (Show Pgs 6A thru 6B) (Show Pgs 6B thru 6C) (Hide Pgs 6A thru 6B)

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

OWNERS		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES	
Name	Ownership %	Name	City	Name	City
ANTARES		ANTARES		ANTARES	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ Yes ☐ No

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for the following costs as specified for this form:

Schedule	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Costs of Related Organization	Adjustments to Related Organization Costs (Section 6)
1	V	MANAGEMENT FEES	100,000				-100,000
2	V	PROPERTY TAXES				10,000	10,000
3	V	DEPRECIATION				10,000	10,000
4	V	UTILITIES				10,000	10,000
5	V	INSURANCE				10,000	10,000
6	V	REPAIRS				10,000	10,000
7	V	TRANSPORTATION				10,000	10,000
8	V	FOOD				10,000	10,000
9	V	ENTERTAINMENT				10,000	10,000
10	V	OTHER				10,000	10,000
11	V	TOTAL				100,000	100,000
12	V	NET INCOME					
13	V	NET LOSS					
14	V	TOTAL					

Total must agree with the amount recorded on line 36 of Schedule V.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.

2. For pages 6 thru 6C, the information you enter does not need to be sorted by line reference.

3. For pages 6 thru 6C, a line can be referenced as many times as needed per page.

4. For pages 6 thru 6C, related organization costs for therapy must be referenced as line number 10a.

5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Preview

Sum, 5
-161500
31400
3765
33
63825
420
420
4546
1010
3212
10
140,000

Line 1 2 3 4 5 6 7 9 10 10a 11 12 13 14 15 17 18 19 20 21 22 23 24 25 26 27 30 31 32 33 34 35 36 38 39 40 41 42 43

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	15
16	V						16
17	V						17
18	V						18
19	V						19
20	V						20
21	V						21
22	V						22
23	V						23
24	V						24
25	V						25
26	V						26
27	V						27
28	V						28
29	V						29
30	V						30
31	V						31
32	V						32
33	V						33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$		\$	\$ *	39

Sum_6A

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginn 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. **THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORT**

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608 Report Period Beginning: 01/01/2000Ending: 1/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization ASTA HEALTHCARE COMPANY INCStreet Address 134 NORTH MCLEAN BLVDCity / State / Zip Code ELGIN, IL 60123Phone Number (847)742-8222Fax Number (847)742-9013

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	OFFICER SALARY	PER RESIDENT DAY	160,952	5	\$ 185,000	\$ 185,000	29,144	\$ 33,498	1
2	19	PROFESSIONAL FEES	PER RESIDENT DAY	160,952	5	20,792		29,144	3,765	2
3	20	DUES	PER RESIDENT DAY	160,952	5	182		29,144	33	3
4	21	CLERICAL	PER RESIDENT DAY	160,952	5	352,482	316,460	29,144	63,825	4
5	27	EMPLOYEE BENEFITS	PER RESIDENT DAY	160,952	5	50,414		29,144	9,129	5
6	24	EDUCATION	PER RESIDENT DAY	160,952	5	2,319		29,144	420	6
7	25	TRANSPORTATION	PER RESIDENT DAY	160,952	5	30,630		29,144	5,546	7
8	26	INSURANCE	PER RESIDENT DAY	160,952	5	5,850		29,144	1,059	8
9	35	EQUIPMENT LEASE	PER RESIDENT DAY	160,952	5	17,736		29,144	3,212	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 665,405	\$ 501,460		\$ 120,487	25

Print Preview

Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	AT & T		X	PURCHASED PHONE SYS	\$352.00	11/27/96	\$ 21,134	\$ 3,875	11/27/01	21.67	\$ 1,047	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	AMERICAN NATIONAL BANK	X		WORKING CAPITAL	INTEREST	REVOLV	375,000	REVOLV	PRIME+		31,579	7	
8												8	
9	TOTAL Facility Related				\$352.00		\$ 21,134	\$ 378,875			\$ 32,626	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 21,134	\$ 378,875			\$ 32,626	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview

Facility Name & ID Number: **ASTA CARE CENTER OF ELGIN**# **0041608** Report Period Beginning: **01/01/2000** Ending: **12/31/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	56,561	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	59,779	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3,218	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	59,779	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND <u>378</u> For 19 <u>98</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	(378)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	62,619	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	55,077	8		
	1996	42,573	9		
	1997	55,610	10		
	1998	56,561	11		
	1999		12		

	FOR OFF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL	15	LESS REFUND FROM LINE 6 \$	15
THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.	16	AMOUNT TO USE FOR RATE CALCULATIC \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 0 B. General Construction Type: Exterior Frame Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO

If so, please complete the following:

1. Total Amount Incurred: **3,667** 2. Number of Years Over Which it is Being Amortized: **5**

3. Current Period Amortization: 733 4. Dates Incurred: 3/29/96

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4
	Use	Square Feet	Year Acquired	Cost
1		0		\$
2				
3	TOTALS	0		\$ 0

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	FLOOR DRAIN			1997	1,297	33	39	33		117	9
10	INSTALL SHOWER VALVE AND DRAIN			1997	4,142	105	39	105		373	10
11	RE KEY DOOR LOCKS			1997	4,085	104	39	104		369	11
12	NEW AIR VENTS			1997	616	18	39	18		63	12
13	FIRE ALARM SYSTEM			1997	2,192	56	39	56		198	13
14	AWNINGS			1997	1,020	26	39	26		92	14
15	SEWAGE EJECTOR PUMP			1998	3,961	102	39	102		267	15
16	HOT WATER PUMP			1998	5,439	139	39	139		307	16
17	AWNING			1999	685	25	27.5	25		39	17
18	FLOORING			1999	2,474	90	27.5	90		139	18
19	ELECTRICAL WORK			1999	9,378	341	27.5	341		526	19
20	MAGNETIC DOOR LOCKS			1999	2,054	74	27.5	74		114	20
21	FIRE SPRINKLER SYSTEM			1999	3,868	141	27.5	141		217	21
22	BOILER			1999	4,890	178	27.5	178		274	22
23	NURSE STATION			2000	16,280	321	27.5	321		321	23
24	CONDENSING UNIT			2000	4,683	92	27.5	92		92	24
25	WATER HEATER			2000	8,731	172	27.5	172		172	25
26	POWER VENT FOR WATER HEATER			2000	2,682	53	27.5	53		53	26
27	NEW WALLS			2000	2,000	39	27.5	39		39	27
28	HOT WATER PIPING			2000	4,708	93	27.5	93		93	28
29	DRAPERIES			2000	2,303	486	10	115	(371)	115	29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 2,688		\$ 2,317	\$ (371)	\$ 3,980	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginning:

01/01/2000(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Page 12B

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginning:

01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

0041608

Report Period Beginning:

Page 12C

01/01/2000 Ending: 12/31/2000

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Page 12D

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608Report Period Beginning: 01/01/2000 Ending: 12/31/2000**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 124,076	\$ 17,403	\$ 12,408	\$ (4,995)	10	\$ 41,768	37
38	Current Year Purchases	20,808	2,675	1,040	(1,635)	10	1,040	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 144,884	\$ 20,078	\$ 13,448	\$ (6,630)		\$ 42,808	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	ADMINISTRATIVE	1991 FORD	1997	\$ 2,552	\$ 281	\$ 510	\$ 229	5	\$ 2,040	42
43										43
44										44
45										45
46	TOTALS			\$ 2,552	\$ 281	\$ 510	\$ 229		\$ 2,040	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 23,047	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 16,275	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (6,772)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 48,828	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	FURNITURE 1997	\$ 7,768	\$ 930	\$ 5,442	52
53					53
54					54
55					55
56					56
57	TOTALS	\$ 7,768	\$ 930	\$ 5,442	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease ELGIN NURSING HOME PROPERTY L.L.C.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☒ YES ☐ NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>102</u>	<u>3/26/96</u>	\$ <u>428,007</u>	<u>30</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>102</u>		\$ <u>428,007</u>			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☒ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipm: \$ 7,185 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 3/26/96

Ending 3/26/26

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/2001 \$ 449,771

13. 12/31/2002 \$ 454,607

14. 12/31/2003 \$ 454,607

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.**THE FACILITY HIRES ONLY TRAINED AIDES.**2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐

HOURS PER AIDE _____

3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐

HOURS PER AIDE _____

B. EXPENSES**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOMEIn the box below record the amount of income your
facility received training aides from other facilities\$ **D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.**Print Preview**

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ies.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 14,902	\$		\$ 14,902	1
2	Licensed Speech and Language Development Therapist		hrs			13,836			13,836	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			18,577			18,577	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				19,005		19,005	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify):					17,421	21,765		39,186	13
14	TOTAL			\$		\$ 64,736	\$ 40,770		\$ 105,506	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

[Print Preview](#)

XV. BALANCE SHEET - Unrestricted Operating Fund.

0041608

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

As of 12/31/2000

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 96,234	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	425,120		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,465		6
7	Other Prepaid Expenses	357		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): REAL ESTATE ESCROW	51,167		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 585,343	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	85,185		15
16	Equipment, at Historical Cost	149,739		16
17	Accumulated Depreciation (book methods)	(108,345)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	3,667		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,543)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): COMPUTER SOFTWARE	12,814		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 139,517	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 724,860	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 178,510	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	375,000		29
30	Accrued Salaries Payable	16,095		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,015		31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,779		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTIES	127,342		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 762,741	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	473,875		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO MICHAEL GILLMAN	151,408		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 625,283	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,388,024	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (663,164)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 724,860	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (461,746)	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (461,745)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(201,419)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (201,419)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (663,164)	24 *

* This must agree with page 17, line 47.

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STATE OF ILLINOIS

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Facility Name & ID Number ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,892,688	1
2	Discounts and Allowances for all Levels	6,254	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,898,942	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	97,249	5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 97,249	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,898	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,898	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	490	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 490	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,998,579	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 698,752	31
32	Health Care	1,045,174	32
33	General Administration	738,990	33
B. Capital Expense			
34	Ownership	555,578	34
C. Ancillary Expense			
35	Special Cost Centers	105,506	35
36	Provider Participation Fee	55,998	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,199,998	40
41	Income before Income Taxes (line 30 minus line 40)**	(201,419)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (201,419)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1 Director of Nursing	1,809	1,964	\$ 60,737	\$ 30.93	1
2 Assistant Director of Nursing					2
3 Registered Nurses	16,842	18,063	348,078	19.27	3
4 Licensed Practical Nurses	3,557	3,918	70,568	18.01	4
5 Nurse Aides & Orderlies	33,050	34,164	351,209	10.28	5
6 Nurse Aide Trainees					6
7 Licensed Therapist					7
8 Rehab/Therapy Aides	3,955	4,088	42,021	10.28	8
9 Activity Director	1,933	2,136	25,008	11.71	9
10 Activity Assistants	2,949	3,175	22,074	6.95	10
11 Social Service Workers	1,979	2,171	25,866	11.91	11
12 Dietician					12
13 Food Service Supervisor	1,882	2,131	28,405	13.33	13
14 Head Cook	10,267	11,177	90,239	8.07	14
15 Cook Helpers/Assistants	6,504	6,974	44,616	6.40	15
16 Dishwashers					16
17 Maintenance Workers	2,050	2,177	28,248	12.98	17
18 Housekeepers	23,552	25,105	163,799	6.52	18
19 Laundry	6,063	6,419	40,093	6.25	19
20 Administrator	1,954	2,139	67,798	31.70	20
21 Assistant Administrator					21
22 Other Administrative					22
23 Office Manager					23
24 Clerical	8,385	9,039	133,412	14.76	24
25 Vocational Instruction					25
26 Academic Instruction					26
27 Medical Director					27
28 Qualified MR Prof. (QMRP)					28
29 Resident Services Coordinator					29
30 Habilitation Aides (DD Homes)					30
31 Medical Records	1,463	1,569	21,642	13.79	31
32 Other Health Care(specify)					32
33 Other(specify)					33
34 TOTAL (lines 1 - 33)	128,194	136,409	\$ 1,563,813 *	\$ 11.46	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35 Dietary Consultant	M	\$ 4,560	1-3	35
36 Medical Director	O	6,500	9-3	36
37 Medical Records Consultant	N	1,440	10-3	37
38 Nurse Consultant	T	0	10-3	38
39 Pharmacist Consultant	H	600	10-3	39
40 Physical Therapy Consultant	L	2,270	10a-3	40
41 Occupational Therapy Consultant	Y	1,430	10a-3	41
42 Respiratory Therapy Consultant		0	10a-3	42
43 Speech Therapy Consultant	F	0	10a-3	43
44 Activity Consultant	E	2,809	11-3	44
45 Social Service Consultant	E	0	12-3	45
46 Other(specify)	S			46
47 <u>PSYCHO-SOCIAL CONSULTANT</u>		1,285	10-3	47
48				48
49 TOTAL (lines 35 - 48)		\$ 20,894		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50 Registered Nurses		\$	10-3	50
51 Licensed Practical Nurses			10-3	51
52 Nurse Aides	179	3,405	10-3	52
53 TOTAL (lines 50 - 52)	179	\$ 3,405		53

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